Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: COMPLETED HCA-0058 B WING 05/21/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1100 H STREET NW SUITE 940 TLC HEALTH CARE SERVICES SOUTHEAST, L WASHINGTON, DC 20005 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) H 000 INITIAL COMMENTS H 000 An annual survey was conducted from 05/16/18 through 05/21/18 to determine compliance with the District of Columbia's Home Care Agency Regulations (Title 22 B DCMR Chapter 39). The Home Care Agency (HCA) provides home care services to 102 patients and employs 20 staff. The findings of the survey were based on a review of eight current patient records, two discharged patient records, employee records. and seven complaints. The findings were also based on five home visits, ten current patient telephone interviews, and patient/staff interviews. Listed below are abbreviations used throughout the body of this report: CHF - Congestive Heart Failure DM - Diabetes Mellitus DON - Director of Nursing HCA - Home Care Agency HHA - Home Health Aide POC - Plan of Care SN - Skilled Nurse H 227 3909.2 DISCHARGES TRANSFERS & H 227 Director of Operations will in-service clinicians 6/12/18 REFERRALS on D.C. Regulation 3909.2 which states each patient shall receive written notice of discharge Each patient shall receive written notice of or referral no less than seven (7) calendar days discharge or referral no less than seven (7) prior to the action. A copy of the regulation will calendar days prior to the action. The seven (7) be provided to all disciplines. day written notice shall not be required, and oral Director of Operations/Clinical Manager/ notice may be given at any time, if the transfer, Designee will audit charts of all discharged 7/12/18 referral or discharge is the result of patients beginning week of 6/11/18 until 100% compliance is achieved. Any issues that are identified will be reviewed with the clinician one on one to assure they have an understanding of the requirements. One-on-one education to be

Health Regulation & Licensing Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

provided by Director of Operations/Clinical...

If continuation sheet 1 of 6

(X6) DATE

Health	Regulation & Licensii	ng Administration			FORM APPROV	
STATEME	NT OF DEFICIENCIES N OF CORRECTION	F DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A, BUILDING:		
		HCA-0058	B WING		05/04/2040	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DORESS CITY	, STATE, ZIP CODE	05/21/2018	
		4400 U.G	TREET NW			
TEO IIE.	ALTH CARE SERVICE	S SOUTHEAST I	GTON, DC			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTION OF THE APPROPERTIES OF THE A	D BE COMPLET	
H 227	Continued From page	ge 1	H 227	Continued From page 1		
	This Statute is not met as evidenced by: Based on interview and record review, the facility			Manager/Designee.		
				Continued monitoring will be on an or	n-going	
	failed to ensure that	each patient received written		basis with our Performance Improven	nent Quarto	
	notification prior to d	lischarge at least seven		quarterly chart audits by the Director	of	
	calendar days prior to the action for two of two discharged patients (Patients #9 and #10).			Operations/Clinical Manager for compliance with 7 day minimum notice of discharge.	oliance	
	dioonarged patients	(1 attents #9 and #10)		- With 7 day minimum notice of dischar	BC.	
	Findings included:			j		
	1 On 05/17/18 at 19	2:30 PM, review of the				
	medical record for P	atient #9 showed that the				
	patient was informed	of his/her discharge on				
	05/10/18 and was dis	scharged from the agency on				
	05/14/18.					
	2. On 05/17/18 at 1:1	15 PM, review of the medical				
	record for Patient #1	0 showed that the patient				
	was informed of his/h	ner discharge on 04/27/18				
	and was discharged 04/27/18.	from the agency on				
	04/2//16.					
	On 05/17/18 at 3:00 i	PM, during interview, the				
	DON acknowledged i	that the patients were not				
	given seven days not	ice prior to discharge from				
3	the agency. The DO	N further stated that all staff				
	will receive in-service	training regarding the				
1	prior to discharge.	patients seven days notice				
H 363 (	3914.3(I) PATIENT PI	AN OF CARE	H 363	Director of Operations/Clinical Manage	er will 5/34/40	
٦			1	amend the emergency statement that	is entered	
	ine plan of care shall	include the following:		on all plan of cares to reflect D.C. Regu		
	l) Identification of em	nlovees in charge of		3914.3 (1)		
r	nanaging emergency	rituations:		<ul> <li>-identification of employees in charge managing emergency situations.</li> </ul>	of	
	. 5 · 5 · 5 · · · · · · · · · · · · · ·			Emergency statement will now read:		
				ALL STAFF OF AMEDISYS WILL CALL 91:	I IN AN	
1	his Statute is not me	et as evidenced by:		EMERGENCY THAT OCCURS WHILE THE		
E	sased on record revie	w and interview, the HCA		THE PATIENT'S HOME. PATIENT AND CA	AREGIVER	
Regulati	on & Licensino Administra	tion		WILL BE TAUGHT EMERGENCY PROTOC	OLS	

STATEME	Regulation & Licensi	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MIII T	IPLE CONSTRUCTION	3) DATE SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A BUILDING	
		HCA-0058	B WING _		05/21/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	C. STATE, ZIP CODE	
TLC HE	ALTH CARE SERVICE		REET NW	SUITE 940	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) E COMPLETE TE DATE
H 363	Continued From pa	ge 2	H 363	Continued From page 2	
	failed to ensure the POC identified the employees in charge of managing emergency situations for eight of eight active patients in the sample (Patients #1, 2, 3, 4, 5, 6, 7, and 8).  Findings included:  Review of the clinical records for Patients #1, 2, 3, 4, 5, 6, 7 and 8 on 05/16/18 through 05/17/18 showed POCs that failed to contain a statement identifying the employees within the agency who are in charge of managing emergency situations.  During an interview on 05/17/18 at 3:20 PM, the DON said that a statement will be added to all POCs to identify the DON or Administrator as the employees in charge of managing emergency situations.			INCLUDING CALLING THE DIRECTOR OF COPERATIONS/ADMINISTRATOR WHO IS RESPONSIBLE FOR MANAGING EMERGENCY SITUATIONS.  Director of Operations/Clinical Manager was addited from the property of	CY ill
				audit 5 five random plan of cares per week ensure the amended emergency statemen included. This will happen each week until 100% compliance is achieved. Issues identified will be reviewed with empand one-on-one counseling provided by Director of Operations.	it is I ployee
				Continued monitoring will be on an on-goir basis with our Performance Improvement quarterly chart audits by the Director of Operations/Clinical Manager for compliance	
H 399	3915.10(f) HOME HE AIDE SERVICE	EALTH & PERSONAL CARE	H 399	Director of Office Operations/Clinical Mana will hold in-service for home health aide to	
f	Personal care aide di following:	luties may include the	,	instruct on how to complete a coordination note with each home health a visit which records the patient's physical	
F	f) Observing, recordi patient's physical con appearance;	ing, and reporting the dition, behavior, or		condition, behavior, or appearance. Home health aide will be instructed regarding reporting any changes in the patient's cond to the RN or Clinical Manager and documenthis in the visit note.	dition nting
fa re o	ailed to ensure PCAs eported the patient's r appearance for one	et as evidenced by: ew and interview, the agency s observed, recorded and physical condition, behavior e of one active patient in the A service (Patient #1).		Director of Operations/Clinical Manager wi audit 5 patient charts per week for patients receiving aide services, beginning week of 6/18/18 to assure home health aide is documenting an assessment of the patient condition in each visit note until 100% compliance is met.	s //16/18
F	indings included:			Continued monitoring will be on an on-goir basis with our Performance Improvement quarterly chart audits by the Director of Operations/Clinical Manager for compliance	ng

Health F	Regulation & Licensin	g Administration			TORWAPPROVEL
STATEMEN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G:	X3) DATE SURVEY COMPLETED
		HCA-0058	8 WING_		05/21/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS CITY	STATE, ZIP CODE	2012112010
TICHEA	LITH CARE CERNICE	4400 U	STREET NW		
TEC REA	ALTH CARE SERVICES		NGTON, DC		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
H 399	Continued From pag	је 3	H 399		
	On 05/16/18 at 9:30 clinical record shows period of 04/23/18 the contained a physicial time a week for one for three weeks to propersonal care.  Review of the HHA or show that the HHA or reported the patient's or appearance during On 05/16/18 at 11:00 confirmed the survey DON said that the HI to allow the HHAs to physical condition, be patients to whom the	AM, review of Patient #1's ed a POC with a certification brough 06/21/18. The POC in's order for HHA service or week and two times a week rovide assistance with the tote dated 04/26/18 failed to bserved, recorded and a physical condition, behavior this visit.  DAM, interview with the DON for findings. Additionally, the HA timesheets will be revised observe and document the ehavior or appearance of all y are assigned.	r I		
S r L iii T E fa p ttr (F	registered nurse, or bunder the supervision accordance with the sased on record reviewed to ensure that so provided in accordance of eight active patients #1, 3, and 8 indings included:  On 05/16/18 at 9:3 linical record showed	es shall be provided by a by a licensed practical nurse of a registered nurse, and e patient's plan of care.  et as evidenced by: ew and interview, the HCA killed nursing services were be with the patients POC for atients in the sample.  O AM, review of Patient #1's a POC with a certification.		Director of Office Operations will in-servicinicians on Policy AA-003, Patient-Asses Reassessment and Policy TX-001, Physici. Orders and Medical Supervision of the Pl Care. Review will include accurately docthe patient's current health status each vaccording to the physician ordered plant of Director of Operations/Clinical Manager audit five random charts per week startimetek of 6/18/18 to ensure clinicians are documenting complete vital signs and he toe assessment per physician ordered placare until 100 % compliance is achieved. Issues identified will be reviewed with the specific clinician and one-on-one counsel provided by the Director of Operations/C Manager.  Continued monitoring will be on an on-go basis with our Performance Improvemen	assment/ an an of umenting visit of care. will 7/16/18 ad to an of e ing linical oing Quarterly
O1		6/21/18 and diagnoses of		Program quarterly chart audits by the Dir of Operations/Clinical Manager for comp	ector

Healt	h Regulation & Licensi				FORM APPROVED		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A BUILDIN	G;	COMPLETED		
		HCA-0058	B WING		05/21/2018		
NAME (	F PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	, STATE, ZIP CODE			
TLC H	EALTH CARE SERVICE	S SUUTHEASTI	REET NW	SUITE 940 20005			
(X4) IE PREFIX TAG	D SUMMARY STATEMENT OF DEFICIENCIES IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
H 45	0 Continued From pa	nge 4	H 450	Continued From page 4			
	CHF and DM. The	CHF and DM. The POC also contained physician		with accurate and inclusive documenta	ation of		
	orders for the SN to	measure abdominal girth and		patient's complete health status according to			
	themself, and repor	e patient is unable to weigh t to the physician a weight		physician ordered plan of care.			
	gain of two pounds	in 24 hours or five pounds in a					
	week. Additionally, skin lesions on the	the SN was to monitor for					
	Review of nursing n	otes dated 04/27/18,					
	documented eviden	and 05/11/18 failed to show ce that the skilled nurse					
	assessed the patien	it for weight gain and/or					
	for skin lesions on the	visits, and failed to monitor					
	<ol> <li>On 05/16/18 at 1</li> <li>#3's clinical record s</li> </ol>	11:30 AM, review of Patient					
	certification of 04/24	/18 through 06/22/18, and a					
	diagnosis of Hyperte	ensive Heart Disease with					
	physician order for the	POC also contained a					
	physician order for the SN to record the patient reported weight or to weigh patient as needed.						
	The SN was ordered	to measure abdominal girth					
	weigh themself, and	f the patient is unable to report to the physician a					
	weight gain of two po	ounds in 24 hours or five			1		
	pounds in a week.						
	Review of nursing notes dated 04/28/18,				1		
	05/01/18, 05/12/18 at	nd 05/14/18 failed to show			1		
documented evidence that the skilled nurse assessed the patient for weight gain and/or							
	edema during these	visits.					
	3. On 05/17/18 at 11	:30 AM, review of Patient			1		
	#8's clinical record sh	nowed a POC with a					
	certification of 03/15/	18 through 05/13/18, and a					
	diagnosis of Type 2 D contained a physician	order for the SN to assess					
	the patient's feet for le	esions at every visit and					

Health F	Regulation & Licensi				FORM APPROV
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SURVEY
		IDEATH IOSTION NOWBER:	A BUILDING		COMPLETED
		HCA-0058	B WING		05/21/2018
AME OF	PROVIDER OR SUPPLIER	STREET A	DORESS, CITY, ST	ATE, ZIP CODE	
LC HEA	ALTH CARE SERVICE		TREET NW SU		
		WASHIN	GTON, DC 200	05	
(X4) ID PREFIX	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CO	(>10)
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	
				DEFICIENCY)	
H 450	Continued From pa	age 5	H 450		
	report blood alucos	e of less than 60 or greater			
	than 300 to the phy	sician.			
	atomical reservation as				
	Review of nursing r	notes dated 03/19/18,			
	03/22/18, 03/27/18	and 04/17/18 failed to show			
	assessed the nation	nce that the skilled nurse nt's feet for lesions at every			
	visit and documente	ed the current glucose level at			
	each visit.	ou the culture glacobe level at			
	During an interview	on 05/17/18 at 3:30 PM, the			
	training on the impo	aff will receive in-service			
	documentation during	nd every visit			
			1		